FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0008524

Facility Name: Fairview Haven

Address: 605-609 North Fourth Street (Number) Fairbury (City) 61739 (Zip Code)

County: Livingston

Telephone Number: (815) 692-2572 Fax # (815) 692-4257

IDPA ID Number: 37-0814781001

Date of Initial License for Current Owners: 1962

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501 (c) 3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Rick Plattner Telephone Number: (815) 692-2572

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2002 to 6/30/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider

(Signed) (Date)
(Type or Print Name) Rick Plattner
(Title) Administrator

Paid Preparer

(Signed) October 28, 2003 (Date)
(Print Name and Title) Mr. Robert Rein, Practitioner
(Firm Name & Address) Robert Rein CPA, P.O. Box 201, Morton, Illinois 61550-0201
(Telephone) (309) 266-8178 Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: ###### Ending: #######

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	63	Skilled (SNF)	63	22,995	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	63	TOTALS	63	22,995	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	61	418	470	949	8
9	SNF/PED					9
10	ICF	8,035	13,348		21,383	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,096	13,766	470	22,332	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.12%

D. How many bed-hold days during this year were paid by Public Aid?
66 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Apartment & Condominium Rental for Elderly

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 10/28/62

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 10/28/62 NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 21 and days of care provided 470

Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/03 Fiscal Year: 06/30/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	227,660	14,173	6,781	248,614		248,614	(71,990)	176,624			1
2	Food Purchase		174,525		174,525		174,525	(12,911)	161,614			2
3	Housekeeping	81,555	16,531		98,086		98,086		98,086			3
4	Laundry	66,162	13,212		79,374		79,374	(6,823)	72,551			4
5	Heat and Other Utilities			94,619	94,619		94,619	(29,567)	65,052			5
6	Maintenance	133,623	74,613	13,194	221,430		221,430	(9,419)	212,011			6
7	Other (specify):*											7
8	TOTAL General Services	509,000	293,054	114,594	916,648		916,648	(130,710)	785,938			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200	(2,000)	5,200		5,200			9
10	Nursing and Medical Records	1,103,990	41,683	69,356	1,215,029	2,000	1,217,029		1,217,029			10
10a	Therapy	76,271		11,551	87,822		87,822		87,822			10a
11	Activities	48,004	7,961	9,247	65,212		65,212		65,212			11
12	Social Services	39,585		1,020	40,605		40,605		40,605			12
13	Nurse Aide Training			2,710	2,710		2,710		2,710			13
14	Program Transportation			3,078	3,078		3,078		3,078			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,267,850	49,644	104,162	1,421,656		1,421,656		1,421,656			16
	C. General Administration											
17	Administrative	58,070			58,070		58,070		58,070			17
18	Directors Fees											18
19	Professional Services			30,512	30,512		30,512		30,512			19
20	Dues, Fees, Subscriptions & Promotions			11,264	11,264		11,264	(1,175)	10,089			20
21	Clerical & General Office Expenses	73,617	6,535	39,678	119,830		119,830	(1,340)	118,490			21
22	Employee Benefits & Payroll Taxes			367,604	367,604	80,215	447,819		447,819			22
23	Inservice Training & Education			935	935		935		935			23
24	Travel and Seminar			12,754	12,754		12,754	(1,149)	11,605			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			153,199	153,199	(80,215)	72,984		72,984			26
27	Other (specify):*											27
28	TOTAL General Administration	131,687	6,535	615,946	754,168		754,168	(3,664)	750,504			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,908,537	349,233	834,702	3,092,472		3,092,472	(134,374)	2,958,098			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassificatio

Facility Name & ID Number Fairview Haven, Inc. #0008524 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			136,293	136,293		136,293	(41,917)	94,376			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			32,564	32,564		32,564	(25,075)	7,489			32
33	Real Estate Taxes			600	600		600	(600)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			169,457	169,457		169,457	(67,592)	101,865			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		23,715	244	23,959		23,959		23,959			39
40	Barber and Beauty Shops			14,629	14,629		14,629		14,629			40
41	Coffee and Gift Shops			5,791	5,791		5,791		5,791			41
42	Provider Participation Fee			34,525	34,525		34,525	(32)	34,493			42
43	Other (specify):*			4,600	4,600		4,600	(4,600)				43
44	TOTAL Special Cost Centers		23,715	59,789	83,504		83,504	(4,632)	78,872			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,908,537	372,948	1,063,948	3,345,433		3,345,433	(206,598)	3,138,835			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/2002 Ending: #######

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(11,881)	2.2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,960	30.3		9
10	Interest and Other Investment Income	(1,698)	32.3		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,600)	43.3		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(120)	20.3		28
29	Other-Attach Schedule	(198,259)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (206,598)		$	30

OHF USE ONLY								
48		49		50		51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (206,598)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			$		47

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
This work paper section is not applicable.						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This work paper section is not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This work paper section is not applicable.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	A.C. Church Hail Assistance	X		Building Addition			$ 338,534	$ 245,329		2.25%	$ 9,187	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 338,534	$ 245,329			$ 9,187	9
	B. Non-Facility Related*											
10	A.C. Church Hail Assistance	X		Building Addition			861,466	624,289		2.25%	23,377	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 861,466	$ 624,289			$ 23,377	14
15	TOTALS (line 9+line14)						$ 1,200,000	$ 869,618			$ 32,564	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7 (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fairview Haven, Inc. COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0008524

CONTACT PERSON REGARDING THIS REPORT Rick Plattner

TELEPHONE (815) 692-2572 FAX #: (815) 692-4257

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Fairview Haven, Inc. STATE OF ILLINOIS # 0008524 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

X. BUILDING AND GENERAL INFORMATION

A. Square Feet: 22,213 B. General Construction Type: Exterior Brick Frame Block Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc. List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	90,000	1962	$ 6,422	1
2					2
3	TOTALS	90,000		$ 6,422	3

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	57		1962	1962	$ 145,220	$ 2,904	50	$ 2,904	$	$ 118,378	4
5	8		1999	1999	354,656		39	9,094	9,094	38,793	5
6											6
7											7
8											8
	Improvement Type**										
9	Additions 65-66			07/01/65	258	5	50	5		194	9
10	Additions 66-67			07/01/66	2,116	42	50	42		1,562	10
11	Additions 67-68			07/01/67	13,436	269	50	269		9,678	11
12	Additions 69-70			07/01/69	1,893	38	50	38		1,289	12
13	Additions 71-72			07/01/71	26,066	521	50	521		16,679	13
14	Additions 72-73			07/01/72	6,314	126	50	126		3,912	14
15	Additions 77-78			01/01/78	4,507	90	50	90		2,297	15
16	Sprinkler System			05/01/79	42,306	846	50	846		20,447	16
17	Generator Room			05/01/79	8,460	169	50	169		4,087	17
18	Additions 78-79			01/01/79	1,578	32	50	32		777	18
19	Driveway Asphalt			08/01/78	1,475		10			1,475	19
20	Generator			09/01/79	19,921		25	797	797	18,992	20
21	Smoke Detector			05/01/80	6,529	261	25	261		6,049	21
22	Lights			06/01/80	4,260	142	30	142		3,277	22
23	Additions 79-80			07/01/79	3,516	70	50	70		1,685	23
24	Smoke Detector			08/01/80	1,575		15			1,575	24
25	Additions 80-81			01/01/81	16,207	324	50	324		7,292	25
26	Porch Enclosure			09/01/81	9,453	189	50	189		4,127	26
27	Dining Room Lighting			09/01/81	2,838	95	30	95		2,069	27
28	Lobby Lighting			12/01/81	763	25	30	25		545	28
29	Linen Exhaust Fan			01/01/82	376		10			376	29
30	Sprinkler System			02/01/82	1,977	40	50	40		851	30
31	Room D2 Addition			02/01/82	432	9	50	9		188	31
32	Room B14 Addition			05/01/82	2,380	48	50	48		1,011	32
33	Exhaust Fan			06/01/82	322		10			322	33
34	New Roof			07/01/82	3,582		10			3,582	34
35	New Air Conditioner			07/01/82	2,590		10			2,590	35
36	Remodel Kitchen & Dining Room			03/01/83	8,205	164	50	164		3,336	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	New Sign	06/01/83	$ 994	$	10	$	$	$ 994	37
38	Landscape	07/01/83	1,455	49	30	49		975	38
39	Attic Fan	12/01/83	1,381		10			1,381	39
40	Kitchen Cabinets & Fixtures	12/01/83	619	31	20	31		606	40
41	Social Service Office	02/01/84	227	5	50	5		92	41
42	Outside Light Fixture	02/01/84	437		10			437	42
43	Blacktop Drive & Trees	01/01/66	2,750		10			2,750	43
44	Laundry Room	01/01/78	14,944	299	50	299		7,521	44
45	Trees	01/01/84	920		10			920	45
46	Concrete Drive	01/01/85	4,199		10			4,199	46
47	Remodeling Activity Rm & D-Wing	01/01/86	167,304	8,365	20	8,365		144,996	47
48	Remodeling C-Wing Bath, Restroom Pilot Lights, D-Wing	01/01/87	8,585	287	30	286	(1)	4,875	48
49	Courtyard--Original Set-up	06/01/87	19,000	633	30	633		10,183	49
50	Remodel Linen Rm, Exit Lights, Utility, Wardrobe Shelves, Nursing Sta	01/01/88	21,731	764	17	1,281	517	19,655	50
51	Courtyard	04/01/88	1,827	61	30	61		930	51
52	Patio Roof	07/01/89	2,576	129	20	129		1,934	52
53	Attic Ceiling	01/16/90	452		10			452	53
54	New Roof	06/28/91	21,664	867	25	867		10,403	54
55	Plumbing-New Faucets-Resident Rooms	03/02/92	6,148		10			6,148	55
56	Carport-Entryway Cover	12/01/92	15,403	1,027	15	1,027		11,896	56
57	Kitchen Remodeling	04/12/92	173,371	7,274	25	6,935	(339)	72,863	57
58	Office Remodel	04/01/94	20,943	838	25	838		7,751	58
59	Kitchen Remodeling & Cabinets	10/01/93	14,811	816	10	684	(132)	14,811	59
60	Kitchen Door, Trees, Carpet	01/01/94	2,855	190	15	190		1,796	60
61	Sewer Extension	02/28/95	2,697	180	15	180		1,500	61
62	Room B-1 & Drug Room Remodel	02/28/95	833	33	25	33		275	62
63	Replace Main Sprinkler System	04/21/95	2,550	170	15	170		1,393	63
64	Repair Dining Room Ice Machine Wall	03/13/96	948	38	25	38		277	64
65	Front Parking Lot & Sidewalk	11/01/95	20,675	1,378	15	1,378		10,560	65
66	Door Alarm System	05/01/95	6,226		7			6,226	66
67	Ceiling Mount Smoke Detectors-Resident Rms	09/27/95	183	7	7	7		183	67
68	Nurse Call System	04/01/95	27,948	2,994	7	3,006	12	27,948	68
69	Ceiling Mount Smoke Detectors-Resident Rms	06/01/96	3,211	421	7	421		3,211	69
70	TOTAL (lines 4 thru 69)		$ 1,263,078	$ 33,265		$ 43,213	$ 9,948	$ 657,576	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,263,078	$ 33,265		$ 43,213	$ 9,948	$ 657,576	1
2	Draperies	01/01/97	1,086	155	7	155		1,007	2
3	Phone System	05/01/97	12,981	1,298	10	1,298		8,001	3
4	Fire Alarm System	03/01/97	324	46	7	46		291	4
5	Door Alarm System	03/01/97	439	63	7	63		399	5
6	Ceiling Mount Smoke Detectors-Resident Rms	01/01/97	191	27	7	27		175	6
7	Door Alarm System	12/01/96	724	103	7	103		678	7
8	Courtyard Landscaping	08/01/96	649	43	15	43		297	8
9	Window Coverings	02/01/98	1,798	257	7	257		1,390	9
10	Intercom System	04/01/98	15,310	2,187	7	2,187		11,474	10
11	Nurse Call System	11/01/97	2,148	307	7	307		1,738	11
12	Fire Alarm System	04/01/98	744	106	7	106		556	12
13	Telephone System	10/01/97	461	66	7	66		379	13
14	Smoke Detectors	01/01/99	108	15	7	15		68	14
15	Bathroom Sprinkler System	05/31/00	1,873	125	15	125		385	15
16	Sink	01/01/00	746	107	7	107		374	16
17	Water Heater	08/01/99	6,669	667	10	667		2,611	17
18	Water Heater	03/12/01	3,647	365	10	365		840	18
19	B Wing Air Conditioner	09/01/00	1,623	232	7	232		656	19
20	Dry Pendants - Shower room	08/16/00	2,762	276	10	276		793	20
21	Nurses Station Carpet	09/15/00	1,151	115	10	115		321	21
22	Large Capacity Water Heater	05/01/01	5,290	529	10	529		1,145	22
23	Telephone System	03/07/02	853	122	7	122		160	23
24	Air Conditioning Unit	05/15/02	1,730	173	10	173		195	24
25	Nurse Call System	01/30/02	64,740	6,474	10	6,474		9,152	25
26	Draperies	02/03/03	1,243	52	10	50	(2)	50	26
27	Phone System Wiring	08/02/02	1,496	196	7	194	(2)	194	27
28	Water Cooler	05/31/03	526	6	7	6		6	28
29	Lightning Arrestors	11/01/02	1,175	78	10	78		78	29
30	Eyewash Station	12/01/02	884	52	10	51	(1)	51	30
31	Firecode Updates	12/01/02	4,850	189	15	187	(2)	187	31
32	Activity Draperies	05/31/03	662	6	10	5	(1)	5	32
33	Concrete Improvements	06/01/03	4,566	25	15	24	(1)	24	33
34	TOTAL (lines 1 thru 33)		$ 1,406,527	$ 47,727		$ 57,666	$ 9,939	$ 701,256	34

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 174,511	$ 21,753	$ 21,753	$	various	$ 130,337	71
72	Current Year Purchases	51,613	5,452	5,452		various	5,452	72
73	Fully Depreciated Assets	367,866				various	367,866	73
74								74
75	TOTALS	$ 593,990	$ 27,205	$ 27,205	$		$ 503,655	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	Ford Van '83 & Paint	'84 & '90	$ 18,557	$	$	$	4	$ 18,557	76
77	Patient Transport	Ford Clubvan Triton V-10 '98	05/01/98	46,290	7,715	7,736	21	5	46,290	77
78	Patient Transport	Dodge Van 96	08/07/01	11,983	1,712	1,712		7	3,281	78
79	Patient Transport	Paint Clubvan	04/01/03	1,147	57	57		5	57	79
80	TOTALS			$ 77,977	$ 9,484	$ 9,505	$ 21		$ 68,185	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,084,916	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 84,416	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 94,376	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 9,960	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,273,096	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87	Non-Care Assets	2,121,511	51,877	576,209	87
88					88
89					89
90					90
91	TOTALS	$ 2,121,511	$ 51,877	$ 576,209	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Fairview Haven, Inc. STATE OF ILLINOIS # 0008524 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [x] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Numbe Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainde of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [x]
- HOURS PER AIDE 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [x]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$ 2,710	$	$ 2,710
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 2,710	$	$ 2,710
10	SUM OF line 9, col. 1 and 2 (e)	$ 2,710			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	6

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained ir your facility. Drop-out costs can only be for costs incurred by your own aides

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a.3	hrs	$	93	$ 5,975	$	93	$ 5,975	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		10	582		10	582	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		45	1,890		45	1,890	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescrpts				8,315		8,315	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Medical Supplies	39.2					15,400		15,400	13
14	TOTAL			$	148	$ 8,447	$ 23,715	148	$ 32,162	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number: Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/03 (last day of reporting year)

This report must be completed even if financial statements are attached

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 415,384	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	169,349		3
4	Supply Inventory (priced at FIFO)	18,592		4
5	Short-Term Investments			5
6	Prepaid Insurance	12,597		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	$ 615,922	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	34,814		13
14	Buildings, at Historical Cost	3,107,278		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	723,109		16
17	Accumulated Depreciation (book methods)	(1,767,327)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	$ 2,097,874	$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	$ 2,713,796	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (35,384)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	(91,407)		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	(865)		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	$ (127,656)	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	(869,618)		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	$ (869,618)	$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	$ (997,274)	$	46
47	TOTAL EQUITY(page 18, line 24)	$ (1,716,522)	$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	$ (2,713,796)	$	48

*(See instructions.)

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: ##### Ending: 6/30/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reportec	$ 1,398,903	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	$ 1,398,903	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	317,619	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	$ 317,619	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	$ 1,716,522	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All require classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ (2,659,188)	1
2	Discounts and Allowances for all Levels	13,592	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	$ (2,645,596)	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	(74,728)	6
7	Oxygen	(8,377)	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	$ (83,105)	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	(5,490)	12
13	Barber and Beauty Care	(12,764)	13
14	Non-Patient Meals	(11,881)	14
15	Telephone, Television and Radio	(9,790)	15
16	Rental of Facility Space		16
17	Sale of Drugs	(10,311)	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	(1,871)	19
20	Radiology and X-Ray		20
21	Other Medical Services	(34,666)	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	$ (86,773)	23
	D. Non-Operating Revenue		
24	Contributions	(367,746)	24
25	Interest and Other Investment Income***	(6,020)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	$ (373,766)	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Residential Revenue	(468,706)	28
28a	Other Income	(5,106)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	$ (473,812)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	$ (3,663,052)	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	916,648	31
32	Health Care	1,421,656	32
33	General Administration	754,168	33
	B. Capital Expense		
34	Ownership	169,457	34
	C. Ancillary Expense		
35	Special Cost Centers	48,979	35
36	Provider Participation Fee	34,525	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	$ 3,345,433	40
41	Income before Income Taxes (line 30 minus line 40)**	(317,619)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	$ (317,619)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,847	2,023	$ 47,423	$ 23.44	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,351	13,162	244,842	18.60	3
4	Licensed Practical Nurses	15,089	16,448	274,873	16.71	4
5	Nurse Aides & Orderlies	45,199	48,582	508,286	10.46	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,305	5,749	76,271	13.27	8
9	Activity Director	1,423	1,544	17,567	11.38	9
10	Activity Assistants	2,872	3,113	30,437	9.78	10
11	Social Service Workers	3,457	3,677	39,585	10.77	11
12	Dietician					12
13	Food Service Supervisor	2,167	2,183	33,229	15.22	13
14	Head Cook					14
15	Cook Helpers/Assistants	18,261	19,313	194,431	10.07	15
16	Dishwashers					16
17	Maintenance Workers	7,134	7,655	133,623	17.46	17
18	Housekeepers	7,437	8,034	81,555	10.15	18
19	Laundry	5,600	6,181	66,162	10.70	19
20	Administrator	1,772	1,828	58,070	31.77	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,934	4,144	73,617	17.76	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Ward Clerk	2,542	2,880	28,566	9.92	33
34	TOTAL (lines 1 - 33)	136,390	146,516	$ 1,908,537 *	$ 13.03	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	117	$ 6,781	1.3	35
36	Medical Director	48	5,200	9.3	36
37	Medical Records Consultant	36	1,740	10.3	37
38	Nurse Consultant	33	2,000	10.3	38
39	Pharmacist Consultant	22	1,540	10.3	39
40	Physical Therapy Consultant	52	3,104	10a.3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	40	2,869	11.3	44
45	Social Service Consultant	16	1,020	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	364	$ 24,254		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10.3	50
51	Licensed Practical Nurses			10.3	51
52	Nurse Aides	2,858	62,360	10.3/10a.3	52
53	TOTAL (lines 50 - 52)	2,858	$ 62,360		53

Facility Name & ID Number: Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/2002 Ending: 6/30/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Rick Plattner	Administrator	-0-	$ 58,070
TOTAL (agree to Schedule V, line 17, col. 1)			$ 58,070

(List each licensed administrator separately.)

B. Administrative - Other

Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3)	$

(Attach a copy of any management service agreement)

C. Professional Services

Vendor/Payee	Type	Amount
Paul Kelson, CPA	Accounting	$ 710
Robert Rein, CPA	Consulting	3,766
Gardner & White	Accounting	1,803
Duane, Morris et al	Legal	23,813
Westervelt & Johnson	Accounting	421
TOTAL (agree to Schedule V, line 19, column 3)		$ 30,512

(If total legal fees exceed $2500 attach copy of invoices.)

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 80,215
Unemployment Compensation Insurance	7,320
FICA Taxes	140,388
Employee Health Insurance	154,459
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Pension Plan	32,436
Employee Life/Disability	22,937
Employee Flexible Spending	1,056
Employee Uniforms	184
Employee Appreciation	8,824
TOTAL (agree to Schedule V, line 22, col.8)	$ 447,819

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 440
Advertising: Employee Recruitment	4,142
Health Care Worker Background Check	432
(Indicate # of checks performed 36)	
Life Services Network of IL	4,519
Dues & Licenses	420
Subscriptions	706
Newspapers	505
Less: Public Relations Expense	( )
Non-allowable advertising	(955)
Yellow page advertising	(120)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,089

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Staff	(625)
Administration	(1,149)
In-State Travel	
Staff	3,306
Administration	1,932
Seminar Expense	
Staff	7,031
Administration	1,110
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,605

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: ###### Ending: ######

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Numbe Fairview Haven, Inc. # 0008524 Report Period Beginning: 7/1/2002 Ending: ######

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network of IL 4,519

(3) Did the nursing home make political contributions or payments to a politica action organization? No If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 24,220 Line 10.2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease. No

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ 34,493
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ Has any meal income been offset against related costs? Yes Indicate the amount. $ 11,881

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.